MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02024

CERTIFICATE OF DEATH

Reg. Diat. No. 787

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: St. Mary's
City or town: Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
St Mary's Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: Mechanicsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. R 2 D F 1
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary Irene Alvey
Mrs John T Alvey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	~~married~~ Widowed

6.(b) Name of husband or wife: Mr John T. Alvey
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 14 1876

8. AGE: Years	Months	Days	If less than one day
68	9	9	..... hrs. ..... min.

9. Birthplace: Morganza St Mary's Co Md (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: none

FATHER
12. Name: Richard Buckler
13. Birthplace: St Mary's Co

MOTHER
14. Maiden name: Rebecca Delan
15. Birthplace: St Mary's Co

16. Informant: Leonard Alvey
Address: Mechanicsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 26 1945 (month) (day) (year)
Cemetery or crematory: St. Joseph Cemetery
Location: Morganza Md
18. Funeral director: W C Mattingly Sons
Address: Leonardtown R F D Md
19. 2/26/1945 (Date rec'd by registrar) Camalier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 23 19 45, at 6.15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Myocardial Failure	3 Day
Due to: Chronic Myocarditis with	not
Due to: Auricular Fibrilation	known
Other conditions: Decubitus	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert T. Fuchs M.D.
M. D. or other
Address: Leonardtown, Md. Date signed 2/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02025

CERTIFICATE OF DEATH

Reg. Dist. No. 28V

1. PLACE OF DEATH:
County: St. Mary's
City or town: Abell
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: St. Mary's
City or town: Abell
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Regina Collins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 12, 1942

8. AGE: Years: 2 | Months: 10 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Abell, St. Mary's, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: James L. Collins
13. Birthplace: Abell, Md

MOTHER
14. Maiden name: Mary Scriber
15. Birthplace: Hollywood, Md.

16. Informant: James L. Collins (Father)
Address: Abell, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 4 1945 (month) (day) (year)

Cemetery or crematory: Sacred Heart
Location: Bush Wood Md
18. Funeral director: W. C. Mattingley Sons
Address: Leonardtown, Md.

19. Feb 8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 3rd 1945, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Febr. 1 1945 to Febr. 3 1945 and that I last saw h.. alive on Febr. 1 1945

Immediate cause of death	DURATION
Heart Failure	15 minutes
Due to: Lobar Pneumonia	2 weeks
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Robert T. Fuchs M.D.
M. D. or other
Address: Leonardtown, Md. Date signed: 2/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

02026

107

1. PLACE OF DEATH

County St. Mary's Registration Dist. No. 2-54

Village or City Abell's No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ~~yrs.~~ ~~mos.~~ 11 ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME George Aloysious Dorsey

(a) Residence: No. Abells St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	Colored	

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of no

6. DATE OF BIRTH (month, day, and year) Feb. 6, 1945

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			8	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. no

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. no

10. Date deceased last worked at this occupation (month and year) no

11. Total time (years) spent in this occupation no

12. BIRTHPLACE (city or town) (State or country) Abell's

FATHER

13. NAME Charles Henry Dorsey

14. BIRTHPLACE (city or town) (State or country) Newtown Neck St. Mary's Co

MOTHER

15. MAIDEN NAME Clara Dorsey

16. BIRTHPLACE (city or town) (State or country) Abell's St. Mary's Co

17. INFORMANT Charles Dorsey Father (Address) Abell's Md.

18. BURIAL, CREMATION, OR REMOVAL Place Sacred Heart Date Feb 15th, 1945

19. UNDERTAKER William Brown (Address) Avenue, Md.

20. FILED Feb 15th, 1945 R. Valleau Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb 15th (Month) Feb. (Day) Thurs. (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Only saw it once, 1945, to Feb 13th, 1945

I last saw him alive on Feb. 13th, 1945; death is said to have occurred on the date stated above, at 6.15 a. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Capillary Bronchitis -	

Other **Contributory Causes** of Importance:

Cold -	

Name of operation no Date of no

What test confirmed diagnosis? Auscultation Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? no Date of Injury no, 19 no

Where did injury occur? no (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury no

Nature of injury no

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify no

(Signed) Walter B. Dent M. D.

(Address) Abell, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

It was seen by me once — when it was 5 days old.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85-0

02027

CERTIFICATE OF DEATH

Reg. Dist. No. 284

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County St Mary's

City or town Mechanicsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County St Mary's

City or town Mechanicsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thaddeus Dotson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Widower

6.(b) Name of husband or wife Cecelia Dotson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1854

8. AGE: Years 90+ | Months 1 | Days 1 | If less than one day ..... hrs. ..... min.

8. Birthplace St Marys Co Md.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Daniel Reeves

13. Birthplace " "

MOTHER 14. Maiden name Dorl Reeves

15. Birthplace " "

16. Informant Samuel Dotson

Address Mechanicsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mch 7/45 (month) (day) (year)

Cemetery or crematory St Joseph's

Location Morganza

18. Funeral director Elmer M Steele

Address Hughesville

19. Mch 8 1945 Leon J Dorsey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1945, at 7 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 26 1945 to Feb 27 1945

and that I last saw him alive on Feb 26 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE Leon J Dorsey M. D. or other

Address Charlotte Hall Date signed 3/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

02028

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:
County St. Marys
City or town Leonardtown,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
St. Marys Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St. Marys
City or town California (Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ella Bradley Hammett

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife John J.
6.(c) If alive, give age 70 years
7. Birth date of deceased (mo., day, yr.) April 19, 1884

8. AGE: Years	Months	Days	If less than one day
61	10		hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Charles Bradley
13. Birthplace Ireland

MOTHER
14. Maiden name Mary Reshneck
15. Birthplace Baltimore, Maryland

16. Informant Mary A. Beckert
Address 1119 Seminary Rd. Silver Spring Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/16/45 (month) (day) (year)
Cemetery or crematory Holy Face
Location Great Mills

18. Funeral director P. B. Robinson
Address Leonardtown, Md.

19. 2-15-1945 (Date rec'd by registrar) p.g. Beane, M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1945 at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 11 1945, to Feb. 13 1945
and that I last saw her alive on Feb. 12 1945

Immediate cause of death	DURATION
Cerebral Embolism	10 minutes
Due to Vegetation in heart valves	5 years
Due to	
Other conditions Lacerations L. face, neck, chest and extremities (auto accident)	30 hours

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 2/11/45
Where did injury occur? Great Mills St Marys Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public road
Means of injury Auto collision Injured at work? No

23. SIGNATURE p.g. Beane, M.D.
M. D. or other
Address Great Mills, Md. Date signed 2-15-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02029

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:

County: St. Marys

City or town: St. Marys City

(If outside city or town limits, write RURAL and give nearest town)

How long is above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: St. Marys

City or town: St. Marys City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Catherine V. Jarboe

3.(b) Social Security Number: 218-14-3356

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 7, 1905

8. AGE: Years	Months	Days	If less than one day
40			..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Telephone operator

11. Industry or business

FATHER — 12. Name: John C. Jarboe

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Minnie U. Fenhagen

MOTHER — 15. Birthplace: Maryland

16. Informant: J. Claude Jarboe

Address: St. Marys City

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/ 1/ 45 (month) (day) (year)

Cemetery or crematory: Holy Face

Location: Great Mills, Md.

18. Funeral director: P. B. Robinson

Address: Leonardtown, Md.

19. Feb 28 1945 (Date rec'd by registrar) J J Beam M D Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27 1945 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Feb 27 1945 and that I last saw h... alive on Feb 26 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J J Beam M D M. D. or other

Address: Great Mills, Md Date signed: Feb 28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

02030

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: St. Marys
City or town: NAS, Patuxent River, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 hours
Hospital, institution, or street address where death occurred:
Dispensary, NAS, Patuxent River, Maryland
How long in hospital or institution? 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residance of mother)
State: Connecticut County:
City or town: Westport
(If outside city or town limits, write RURAL and give nenrest town)
Street No.: 86 Kings Highway
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Willis Hurlbutt Jones, Jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White-US	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8-21-26

8. AGE: Years	Months	Days	If less than one day
18	6	15	hrs. min.

8. Birthplace: Norwalk, Connecticut (Town, county, and state)
10. Usual occupation: U.S. Navy
11. Industry or business:
FATHER 12. Name: Willis H. Jones, Sr.
13. Birthplace: Westport, Conn.
MOTHER 14. Maiden name: Helen Tovey
15. Birthplace: Westport, Conn.
16. Informant: U. S. Navy
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 2-6-45 (month) (day) (year)
Cemetery or crematory:
Location: Westport, Connecticut
18. Funeral director: Robinsons Funeral Home
Address: Leonardtown, Maryland

19. Feb 8 19 45 (Date rec'd by registrar) Canadian Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 February 19 45 at 1205 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6:45 P.M. 2-5 19 45 to 1205 A.M. 2-6 19 45
and that I last saw him alive on 1205 A.M. 2-6 19 45

Immediate cause of death	DURATION
Multiple injuries	
Due to: accident aboard ship.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 2-5-45
Where did injury occur? aboard ship (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: crash of loading boom Injured at work? Yes

23. SIGNATURE: Samuel Zurik
SAMUEL ZURIK, Lt.Comdr. (MC) USN
M. D. or other
Address: NAS, Patuxent River, Md. Date signed: 2-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (173)

02031

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: St. Mary's
City or town: NAS Patuxent River, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Ohio County:
City or town: Cleveland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 9816 Gambier Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II ✓

3. (a) FULL NAME: KUMMERLIN, Robert Jerome Ensign H-V(N) 354 897

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 1, 1923.

8. AGE: Years	Months	Days	If less than one day
22	1	6	hrs. min.

9. Birthplace: Cleveland Ohio (Town, county, and state)
10. Usual occupation: Ensign
11. Industry or business: USNR
FATHER 12. Name: Unknown
13. Birthplace
MOTHER 14. Maiden name: XXXXXXX Unknown
15. Birthplace
16. Informant: U.S. Navy
Address: Patuxent River Md.
17. Transportation (Burial, cremation, or removal. Which?) Date thereof: 2/9/45 (month) (day) (year)
Cemetery or crematory: Cleveland
Location: Ohio.
18. Funeral director: A B Robinson
Address: Leonardtown
19. 2-19-45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 February 1945 at 5:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from not attended 19 to 19 and that I last saw him dead on 7 February 1945

Immediate cause of death	DURATION
Injuries, multiple extreme including 3rd degree burns over entire body	
Due to: Plane crash.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 2-7-45
Where did injury occur: Dare's Beach (City or town) Calvert (County) Md. (State)
Injured at home, farm, industry, public place (where?): Duty flight.
Means of injury: Plane crash Injured at work? Yes

23. SIGNATURE: W. O. Tirrell Jr.
W. O. Tirrell Jr.
Lt.(MC) USNR M. D. or other
Address: NAS Patuxent River Md Date signed: 2-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02032

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: St. Marys

City or town: R.F.D. Leonardtown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: St. Marys

City or town: R.F.D. Leonardtown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth Laschalt

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Killian Laschalt

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): July 8 1870

8. AGE: Years	Months	Days	If less than one day
74	7	2	hrs. min.

9. Birthplace: Vienna, Austria
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Killian Laschalt III

Address: R.F.D. Leonardtown

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 2/ 12/45
(month) (day) (year)

Cemetery or crematory: St. Joseph

Location: Morganza

18. Funeral director: P.B. Robinson

Address: Leonardtown, Md.

19. 2/11 45 Casualties
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10th 1945 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1944, to Feb. 1945;
and that I last saw h.e.r. alive on Jan- 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	Jan 1945
Due to: Arteriosclerosis	7
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none done

Date of op.

Autopsy results: none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Aloysius C. Wild M.D.
M. D. or other

Address: Chaptico Md Date signed: 2/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

02033

CERTIFICATE OF DEATH

Reg. Diat. No. 281

1. PLACE OF DEATH:

County St. Marys

City or town Lexington Park, Pearson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 7 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County St. Marys

City or town Lexington Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Pearson
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas Findlay Lawrie

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Catherine

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) April 26, 1870

8. AGE: Years	Months	Days	If less than one day
75			...hrs. ...min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual occupation carpenter

11. Industry or business

FATHER — 12. Name Peter Lawrie
13. Birthplace Scotland

MOTHER — 14. Maiden name Jessie Findlay
15. Birthplace Scotland

16. Informant Wm.F.T. Lawrie
Address 1507 Alice St. Waycross, Georgia.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/17/45 (month) (day) (year)

Cemetery or crematory Columbia Gardens

Location Arlington, Va.

18. Funeral director P. B. Robinson

Address Leonardtown, Md.

19. 2-16-1945 (Date rec'd by registrar) P.B. Blanton M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13th 1945 at 12:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1945 to Feb. 13-1945 and that I last saw h... alive on Feb. 13 — 1945

	DURATION
Immediate cause of death	
Coronary sclerosis	5 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P.B. Blanton M.D. M. D. or other

Address Great Mills, Md. Date signed 2-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

02034

CERTIFICATE OF DEATH

Reg. Dist. No. 281

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: St. Mary's

City or town: Drayden

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 3 1/2 hours -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: St Mary's

City or town: Drayden Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME James Rudolph Morgan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	Single

6 (b) Name of husband or wife: none

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 10, 1945

8. AGE: Years | Months | Days | If less than one day: 3 hrs. 30 min.

9. Birthplace: Drayden, St Mary's Co. Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Charles Morgan

FATHER 13. Birthplace: St Mary's Co Md.

MOTHER 14. Maiden name: Lillian Mae Whalen

MOTHER 15. Birthplace: Drayden, St Mary's Co.

16. Informant: Lillian Mae Whalen

Address: Drayden, St Mary's Co

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-12-45 (month) (day) (year)

Cemetery or crematory: St Markes

Location: Valley Lee Md

18. Funeral director: J Hooker

Address: Valley Lee Md

19. 2-11- 1945 (Date rec'd by registrar) C. Beane M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 10 1945, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 1945, to Feb. 10 1945, and that I last saw him alive on Feb 10 1945.

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions: Lobar Pneumonia in mother. (Include pregnancy within 3 months of death)	

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Dr. H Pattack M.D. M. D. or other

Address: Pearson Md Date signed 2-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

02035

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County: St Marys

City or town: Piney Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all his life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Maryland County: St Marys

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No. Piney Point Md

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Geo Francis Robinson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col	S

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 18 1945

8. AGE: Years | Months | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Piney Point St Marys Co Md

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Fredrick R. Robinson

13. Birthplace: Washington D C

MOTHER — 14. Maiden name: Cailia Beem

15. Birthplace: St Marys Co Md

16. Informant: Fredrick R Robinson

Address: Piney Point Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 27 45 (month) (day) (year)

Cemetery or crematory: St Georges Cemetary

Location: Valley Lee Md

18. Funeral director: Wm E Mattingley & Sons

Address: Leonardtown Md

19. 2/27/45 19 (Date rec'd by registrar) Cancelled Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 27 19 45 at 1a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 27th 1945 to 19; and that I last saw him alive on Feb 27th 1945 after death 19

Immediate cause of death	DURATION
Pneumonia	1 day
Due to: neglected Bronchitis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Not made

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Francis F Greenwell M D M. D. or other

Address: Leonardtown Md Date signed: Feb 27 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (173)

02036

CERTIFICATE OF DEATH

Reg. Dist. No. 784

1. PLACE OF DEATH:
County: St. Mary's
City or town: US NAS, Patuxent River, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: California County:
City or town: 3740 5th. Ave. San Diego
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SHELTON, Oran Donald

3.(b) Social Security Number: 567-07-4125

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White-US	Married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 14, 1918

8. AGE: Years	Months	Days	If less than one day
27	0	23	hrs. min.

9. Birthplace: Texas (Town, county, and state)
10. Usual occupation: Field Engineer Corp.
11. Industry or business: Consolidated Vultee, Aircraft

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: U. S. Navy
Address: Patuxent River

Transportation (Burial, cremation, or removal. Which?) Date thereof 2/9/45 (month) (day) (year)
Cemetery or crematory: San Diego
Location: California

18. Funeral director: G. B. Robinson
Address: Leonardtown Md.

19. 2-9-45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 February 1945, 19, at 5:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Not attended, 19, to, 19
and that I last saw h alive on, 19

Immediate cause of death	DURATION
Injuries, multiple extreme	
Due to: Plane crash	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 2-7-45
Where did injury occur? Dare's Beach (City or town) Calvert (County) Maryland (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Plane crash Injured at work? Yes

23. SIGNATURE: W.O. Tirrill J. W.O. TIRRILL, Lt.(MC) USNR
M. D. or other
Address: NAS, Patuxent River, Md. Date signed: 2-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

02037

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:

County: St. Marys

City or town: Hermansville (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: St. Marys

City or town: Hermansville (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Daniel G. Stevens

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Margaret J.

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): February 28, 1866

8. AGE: Years: 78 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Deleware

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: Daniel Stevens

13. Birthplace: ~~Unknown~~ Greenwood, Del.

MOTHER — 14. Maiden name: Marry Morris

15. Birthplace: ~~Unknown~~ Farmington, Del.

16. Informant: Robert A. Stevens

Address: Hermansville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2 / 21 / 45 (month) (day) (year)

Cemetery or crematory: Ebenezer

Location: California, Md.

18. Funeral director: P. B. Robinson

Address: Leonardtown, Md.

19. 2-21-1945 (Date rec'd by registrar) P.J. Beary MD Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 19, 1945 at 7:00A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 1, 1940, to Feb 19, 1945 and that I last saw him alive on Feb 16, 1945

Immediate cause of death	DURATION
Coronary sclerosis	5 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: P.J. Beary MD. M. D. or other

Address: Great Mills Md. Date signed 2-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (66)

02038

CERTIFICATE OF DEATH

Reg. Diat. No. 287

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: St. Marys

City or town: Comptom, Md. (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: St. Marys

City or town: Comptom,

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary E, Summerville

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ? 1887 ?

8. AGE: Years	Months	Days	If less than one day
58			..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Charles Combs

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Julia Summerville

MOTHER — 15. Birthplace: Maryland

16. Informant: Thomas Summerville

Address: Comptom, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/15/45 (month) (day) (year)

Cemetery or crematory: St. Francis

Location: Comptom, Md.

18. Funeral director: P. B. Robinson

Address: Leonardtown, Md.

19. 2/14 '45 (Date rec'd by registrar) Cancelled Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12 1945, at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 3 1944, to Feb 12 1945, and that I last saw h[illegible] alive on Feb 11 1945

Immediate cause of death	DURATION
Carcinoma of R Lung	6 weeks
Metastasized from R Breast	
Due to Removed Nov 1944	18 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: F J Greenwell M. D. or other

Address: Leonardtown Date signed: Feb 14 45